Testimony
of American Healthways, Inc.
before the
The Senate Select Committee on Aging

September 19, 2002

Thank you Mr. Chairman.

Mr. Chairman and members of the Committee, my name is Matthew Michela and I am Senior Vice President, Operations of American Healthways of Nashville, Tennessee. On behalf of all of my colleagues and, in particular, our Executive Vice President, Robert Stone who had to regretfully decline your invitation to appear due to a prior commitment, I want to express our appreciation for having the opportunity to testify before you this morning.

American Healthways is the nation's leading and largest independent disease management organization. Today, we provide our award winning and fully accredited services to approximately 600,000 Americans who suffer from diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and asthma. Our services are available from certain health plans in all 50 states, Puerto Rico and the District of Columbia.

In addition to being the first disease management organization in the country to receive accredited status from both the National Committee on Quality Healthcare (NCQA) and URAC/American Accreditation Healthcare Commission, our programs in diabetes, heart failure and coronary artery disease have also been reviewed an approved by a select committee of the faculty of Johns Hopkins representing their schools of medicine, nursing and public health.

American Healthways' disease management programs are provided to a wide variety of populations including HMO, PPO, Medicare + Choice and, for some of our customers,

FEP. We also provide services through, and on behalf of, our customer health plans to many self-funded employers for both their active and under age 65 retired employees. Further, we are the only disease management organization in the country providing services to a Medicare fee-for-service population, specifically one whose care is administered by our customer Hawaii Medical Service Association/Blue Cross and Blue Shield of Hawaii under a cost contract with the Centers for Medicare and Medicaid Services (CMS).

Because of our unswerving commitment to quality and the our constant recognition that it is people's lives with which we are dealing everyday, we have led the way in the disease management industry in submitting our outcomes – both clinical and financial – for third party validation and publication in peer review journals. Copies of several of those outcomes studies have been submitted to staff for review at your pleasure. Of particular note and pertinence to this Committee though, is the unpublished study conducted by Dr. David W. Plocher, vice president of Cap Gemini Ernst & Young with respect to our first 10-month results with approximately 6,000 Hawaii Medicare fee-for-service beneficiaries with diabetes. That study, which staff also has, shows concurrent and statistically significant improvement in all clinical outcomes measures *and* a net, after-fee reduction in total health care cost of approximately $5.1 million, or 17.2% on an inflation adjusted basis.

Those are the kind of results that properly designed and effectively implemented disease management programs can achieved – not just for the commercially insured population, not just for the + Choice population, not just for an employer self-insured population – but for every traditional Medicare beneficiary with chronic disease as well. No wonder that in it's short nine-year history, disease management has found such widespread acceptance – from health plans, employers, consumer and physicians, to regulators – like those at HHS who recognized its inherent value in the drafting of the most recently promulgated HIPAA regulations, to senior Agency staff, like those at CMS who continue to seek meaningful, large scale disease management demonstration projects, and those at CBO who are actively evaluating the potential impact of disease management programs –

even to members of both Houses of Congress who have seen fit to reflect the opportunities offered by disease management in nearly every major piece of health care legislation proposed in the past several years.

The Committee's invitation to testify today asked us to address three areas with respect to our disease management programs: what we do, the importance of accreditation – to us, to the disease management industry and to purchasers, both public and private – and, finally, issues that we believe Congress can help address or resolve in speeding the provision of disease management services and benefits to the elderly, particularly traditional Medicare fee-for-service beneficiaries.

According to the industry standard definition adopted by the Disease Management Association of America,

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

- supports the physician or practitioner/patient relationship and plan of care,
- emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and
- evaluates clinical, humanistic, and economic outcomes on an going basis with the goal of improving overall health.

Disease Management *Components* include:

- Population Identification processes
- Evidence-based practice guidelines
- Collaborative practice models to include physician and support-service providers
- Patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance)
- Process and outcomes measurement, evaluation, and management
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling)

Full Service Disease Management Programs must include all 6 components. Programs consisting of fewer components are **Disease Management Support Services.**

In short, disease management is a treatment support concept predicated on the simple principle that the way to reduce health care cost is to improve health. The goal of all disease management programs is to create and sustain behavior change among patients and providers to assure that the most effective management of each patient's health is achieved in a manner consistent with evidence-based medicine and recognized standards of care. But, while the precepts of disease management are uniform, program design and method of delivery reflect significant differences and, as a result, so do the outcomes that can be achieved.

Accordingly, the key determinant driving our success in achieving positive clinical and financial outcomes isn't really a matter of "what we do;" rather it's a matter of "how we do it."

American Healthways' programs are based on three underlying principles. The first is recognition of the fact that the fundamental interaction in health care is the one between patient and physician. We believe that the entire rest of the health care system exists solely for the purpose of making that interaction more effective, more efficient or, preferably, both. Accordingly, our program are designed to support both sides of that interaction, through direct patient intervention specifically designed to further the physician's plan of care and extend his or her capabilities both beyond the relatively limited amount of direct patient contact they have during quarterly or semi-annual office visits, and also beyond the four walls of their office.

It is in the periods between office visits that patients are essentially responsible for their own care and management and our current delivery system provides little or no support for them in that effort. Direct physician support for this objective provided by "in-market" registered nurses working directly with physicians and

their office staffs to help address issues impeding better adherence to recognized standards of care. In addition, all physicians are provided with "time-of-need" information about our interactions with their patients through a proprietary and secure web-based application that allows them to access data on their patients maintained in our clinical information system.

The second principle underlying our programs is based on our understanding that creating and sustaining behavior change, particularly the lifestyle behavior changes so critical to improving the health of people with chronic disease, is best achieved by creating personal, trusting relationships between patients and caregivers. Accordingly, our program interventions are delivered – mainly by phone – by over 600 highly trained, experienced and caring registered nurses and dietitians who frequently spend significant time helping patient's deal with the realities of life as well as with issues directly related to their disease(s).

That approach underscores the third foundation principle that holds that the patients we work with are people, not diseases. By meeting each patient's needs in the context of where that patient is in the context of their environment and in their approach and willingness to self-manage, we assure that we are always prepared to support whatever increment of behavior change the patient is willing to make.

The clinical and financial success of our programs stands in testimony to the validity of these underlying principles and to the integrity with which we have honored them in their design, implementation and delivery.

The second area the Committee asked us to address was the importance of accreditation to American Healthways, to the industry and to purchasers, both public and private.

American Healthways was an early advocate for accreditation of disease management programs. We convened a physicians' consensus conference on Standards for Disease Management Programs in 1999, and subsequently widely

distributed the conference proceedings to major stakeholder groups. We were enormously pleased that those proceedings became one of the foundation documents for the subsequent efforts of both NCQA and URAC.

Our drive for accreditation of disease management programs had two bases: first, we believe that any organization or industry that accepts the sacred trust of protecting people's health ought to submit its efforts and outcomes to meaningful third-party scrutiny. Second, there was, at the time, no uniformly recognized and accepted definition for disease management, allowing many programs which were little more than thinly disguised marketing efforts preying on a vulnerable population to masquerade under the disease management umbrella. We needed – the industry needed – a reliable, external body to help distinguish not only the *bona fide* from the opportunistic, but equally as important, the programs that were effective from those that, while sounding good, actually produced little or no discernable benefit.

I had the privilege of being a member of the NCQA committee charged with developing their standards and program. Mr. Stone served a similar role for URAC. Having worked to develop the standards, and now having been subjected to meeting them, we can assure you that these two programs meet the objectives that were important to us and, we believe, the industry and potential purchasers of disease management services.

Whether or not these accreditation programs serve that role effectively, however, will be a function of the degree to which they are recognized as meaningful by both the private and public purchaser communities. If accreditation becomes a requirement in order to even be considered for purchase RFP's and Demonstration Project awards, not only will the value of accreditation be enhanced but also, and more importantly, a greater number of organizations will go through the process, greatly increasing the overall quality of disease management programs being delivered.

The last topic the Committee asked us to address today is how Congress can further the provision of proven disease management programs to our nation's seniors, particularly those who rely on traditional Medicare fee-for-service for health care coverage.

At last week's Annual Medicare and Medicaid Conference sponsored by the American Association of Health Plans, David Kreiss, special assistant to CMS Administrator Tom Scully said, "the last frontier in disease management demonstration projects was population based disease management projects focused on outcomes." Mr. Kreiss want on to say that CMS recognized the importance of the next round of demonstration projects being able to show ability to deliver services at scale and that he anticipated a request for proposals would be released in the next month or two.

We would urge this Committee and all Members of Congress to provide whatever support may be required for CMS' efforts in this regard. As we have shown in Hawaii, the provision of effective disease management programs can make a significant difference in the lives of Medicare beneficiaries with chronic disease and also have a significant positive impact on the costs of care that must be sustained by the Medicare Trust Fund. The sooner that CMS and Congress can comfortably conclude that these services are an essential component of Medicare's overall strategic approach to the delivery of services, the sooner every Medicare beneficiary – in fact every citizen – can begin to derive the benefits disease management programs can provide.

Finally, we would ask Congress to quickly revisit the issue of Federal pre-emption with respect to HIPAA and state privacy laws. Disease management programs work best when there is a secure, but unimpeded flow of information among plans, providers and disease managers. This fact has already been recognized in the current HIPAA regulations. But health care, while delivered locally, is no longer bought or paid for that way. National health plans must develop and provide uniform services to national corporations who expect those programs to be uniform irrespective of where their offices are or where their employees live. The continued ability of the individual states to enact governing statutes more restrictive than HIPAA, presents a significant barrier to our industry being able to

easily meet those requirements. Further, when the day comes that disease management services are made available to all Medicare beneficiaries, no just those enrolled in selective + Choice programs, the issue of the primacy of state or Federal privacy rules will have to have been resolved.

Let me conclude, Mr. Chairman, by reiterating the simple truth that disease management programs – properly designed, implemented and delivered – improve health outcomes and reduce the cost of care irrespective of medical delivery model used or financing mechanism employed. Like Intel, disease management functions inside the existing delivery system, making it better and improving its outcomes. Accordingly, the introduction of disease management services to Medicare beneficiaries with chronic disease does not require reform of either the health care system or the Medicare program. What it does require is the support of this Committee, this Congress and this administration to assure that the benefits that can be achieved are realized in the shortest possible time.

Thank you.